

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 6

02697

CERTIFICATE OF DEATH

Reg. Dist. No. 51

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
 County Calvert
 City or town Cal. Co. No. 9 Prince Fred.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, Institution, or street address where death occurred: Cal. Co. Hosp.

How long in hospital or institution? 4 days

3. (a) FULL NAME

4. Sex Female 5. Color or race B. 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) May 29, 1937 6. (c) If alive, give age years

8. AGE: Years 7 Months 9 Days 23 If less than one day hrs. min.

9. Birthplace Calvert County

(Town, county, and state)

10. Usual occupation J

11. Industry or business

MOTHER FATHER 12. Name George Louis Brown 13. Birthplace Calvert Co. Md.

14. Maiden name Mary Ellen Taylor

15. Birthplace Calvert Co. Md.

16. Informant George L. Brown

Address Huxleytown

17. Burial Date thereof 3-14-45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Patuxent

Location Huxleytown

18. Funeral director P. E. Sewell

Address Prince Frederick

19. 3-22-45 19. Date rec'd by registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Parson County Calvert

City or town Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22, 1945 at 8:50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 21, 1945, to 1945, 19.

and that I last saw her alive on 19.

Immediate cause of death

Necrotic Convulsions

Due to

Stated Medic + Acute

Stated Medic + Acute

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of.

Where did injury occur? (City or town) (County) (State)

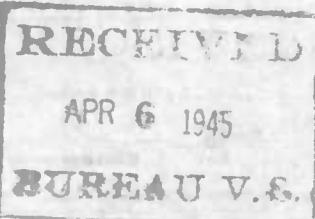
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Borge D. S. M. D. or other

Address Prince Frederick Date signed 3/22/45



~~M~~
PLEASE WRITE PLAINLY, WITH UNFADING INK.
Supply every item of information carefully. The correct age
is especially important. Physicians please write the causes of death clearly and legibly.

Evidence for addition of MARYLAND STATE DEPARTMENT OF HEALTH
residence of deceased is shown on 2411 N. Charles St., Baltimore ~~MD~~

02698

FILM NO. G 94 MAY 11 1945

CERTIFICATE OF DEATH

Reg. Dist. No. 57

1. PLACE OF DEATH:

County.....

Calvert

City or town.....

Prince Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

5 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Elisia Chase

4. Sex

5. Color or race

m

c

6. (a) Single, married, widowed, or divorced

w.

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

1879

8. AGE:

66

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

Cal. County Md.

(Town, county, and state)

10. Usual occupation.....

Farmer

11. Industry or business

12. Name.....

John S Chase

13. Birthplace

Cal. Co Md.

14. Maiden name.....

Elizabeth Coats

15. Birthplace

Cal. Co. Md.

16. Informant.....

Viola Chase

Address

Prince Frederick

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....
(month) (day) (year)
3 - 23 45

Cemetery or crematory.....

Young

Location.....

Huntington

P.E. Sewell

18. Funeral director.....

Address

Prince Frederick

19. Date rec'd by registrar

3 - 22

1945

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Calvert

City or town.....

Prince Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

-

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 22 1945 at 1:39 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-19 1945 to 2-21 1945

and that I last saw h. m. alive on 3-3-45

Immediate cause of death.....

Cerebral accident,

DURATION

Due to.....

Hypertension.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

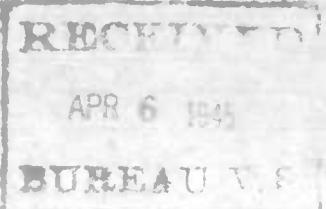
Means of injury.....

Injured at work?

23. SIGNATURE.....

Deputy Medical Examiner for Calvert Co. MD. of other

Address..... Prince Frederick, Md. Date signed



Evidence for change of
year of birth is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 41

02699

FILM G 94 MAY 11 1945

Reg. Dist. No. 51

CERTIFICATE OF DEATH

I. PLACE OF DEATH

County

Calvert

City or town

Chesapeake, md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

mary Hawkins Curtis.

4. Sex

F

5. Color or race

C.

6. (a) Single, married, widowed, or divorced

m.

6. (b) Name of husband or wife

Wesley Curtis.

7. Birth date of

deceased (mo., day, yr.)

Sept 14 - 1879, 1878

8. (c) If alive, give age years

8. AGE:

66

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

md

(Town, county, and state)

10. Usual occupation

Domestic.

11. Industry or business

MOTHER FATHER

12. Name

Talf Norford

13. Birthplace

md

14. Maiden name

Cordelia Earls

15. Birthplace

md.

16. Informant

McKenley Hawkins.

Address

Chesapeake, md,

17. Burial

(Burial, cremation, or removal. Which?)

5t. Edmond.

Date thereof 3-17, 45

(month) (day) (year)

Cemetery or crematory

Location

Calvert, md

18. Funeral director

P.E. Sewell.

Address

Prince Fred, md.

19. (Date rec'd by registrar)

19 45

J. N. King

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

Calvert,

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

3-19, 1945, at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1945, to 3/18, 1945

and that I last saw deceased alive on 19

Immediate cause of death

Acute Cardiac Failure

DURATION

Due to Hypertension

Due to

Other conditions

Diabetes Mellitus

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

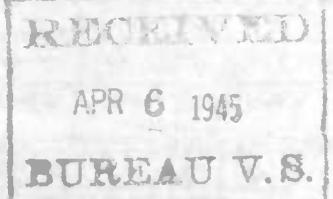
Injured at work?

23. SIGNATURE

M. D. or other

Address

Jesse H. Deenick Date signed 3/19/45



PLEASE WRITE PLAINLY, WITH UNFADING INK.
Supply every item of information carefully. The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 168

02700

1944
28
16

CERTIFICATE OF DEATH

Reg. Diat. No. 51

1. PLACE OF DEATH:

County

Calvert
Island Creek

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

7

5. Color or race

C

6.(a) Single, married, widowed, or divorced

S

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

deceased (mo., day, yr.)

Dec 15

1916

8. (c) If alive, give age years

8. AGE: Years Months Days If less than one day

28

3

10

.....

hrs.

..... min.

9. Birthplace

Island

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

12. Name

Major

Son

13. Birthplace

Baltimore

Maryland

14. Maiden name

Rosa Johnson

15. Birthplace

Island

16. Informant

Rosa Johnson

17. Address

Island Creek

18. Burial

Date thereof

3 - 26, 45

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Island Creek

19. Location

Calvert

20. Funeral director

P. E. Sewell

Address

Primer Frederick and

21. Date rec'd by registrar

3-26

1945

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Calvert

City or town

Island Creek

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

3 25

1945 at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

10

19

and that I last saw h. alive on .19. , 10. , 19.

Immediate cause of death

Cerebral hemorrhage due
to head injuries

DURATION

16 hrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Unverified Date of 3/24/45

Where did injury occur?

Went to Calvert (City or town) County (State)

Injured at home, farm, industry, public place (where?)

Talbot Place (City or town) County (State)

Means of injury

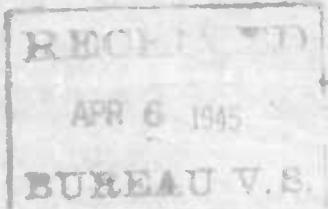
Head injury Injured at work? No

23. SIGNATURE

H. W. Ward M. D. or other

Address

Drury Rd Date signed 3/25/45



PLEASE WRITE PLAINLY, WITH UNFADING INK.
Supply every item of information carefully. The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for addition of MARYLAND STATE DEPARTMENT OF HEALTH
residence of deceased is shown on 2411 N. Charles St., Baltimore 1860
Film No. G94 - May 15, 1945

02701

52

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
County..... Calvert Co
City or town..... Chaney
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....
Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Calvert
City or town..... Chaney
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)

3. (a) FULL NAME

George ERNEST JENKINS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	

6.(b) Name of husband or wife.....

B. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Aug 8 1944

8. AGE: Years Months Days If less than one day

8 9 hrs. min.

9. Birthplace..... Chaney
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name..... GILBERT JENKINS

MOTHER 13. Birthplace..... Cal Co

14. Maiden name..... Emma Johnson

15. Birthplace..... Friendship Md.

16. Informant.....

Address.....

17. Friendship Date thereof 3/19/45
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Carter's Chapel

Location..... Friendship

18. Funeral director..... T. A. Hardisty

Address..... Silverville Md.

19. March 18, 1945
(Date rec'd by registrar) Tom H. Hardisty
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

3/17/45 1945 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3/15 1945 to 3/17 1945

and that I last saw h. in alive on 3/17 1945

Immediate cause of death Cerebral hemorrhage from fall

Due to.

Due to.

Other conditions.

(Include pregnancy within 8 months of death)

Major findings or operations.

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Where did injury occur? Chaney Cal Co MD

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Fall Injured at work?

23. SIGNATURE

Hyl W Ward M. D. or other

Address..... Ormeys Md Date signed 3/17/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

02702

CERTIFICATE OF DEATH

Reg. Dist. No. 57

1. PLACE OF DEATH:

County.....

Calvert Co.

City or town.....

Hospital

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Seoir Jones, Levi

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

m.

c.

m.

6.(b) Name of husband or wife.....

martha Jones

May 5, 1882

6.(c) If alive, give age 52 years

52

7. Birth date of deceased (mo., day, yr.) 3-5-1882

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

md.

(Town, county, and state)

10. Usual occupation.....

farmer

11. Industry or business

George Jones.

MOTHER FATHER

12. Name.....

George Jones.

13. Birthplace.....

md.

14. Maiden name.....

mariah Gordie

15. Birthplace.....

md.

16. Informant.....

Roland Jones.

Address

Huntingtown, md,

Burial

Date thereof Mar. 6, 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Patuxent Church.

Location

Calvert.

18. Funeral director.....

P.C. Sewell.

Address

Pr. Frederick, md,

3-6

1945

J. N. King

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

md County.....

City or town.....

Huntingtown md.

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

3-4, 1945, at 3 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw h..... alive on

Immediate cause of death.....

Fecal Hernorrhage

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury.....

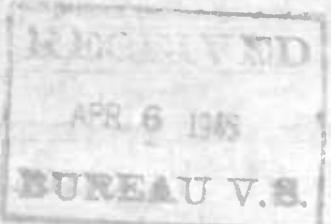
Injured at work?

23. SIGNATURE.....

Date signed

M. D. or other

Address.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

02703

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

73

5. Color or race

W

6. (a) Single, married, widowed, or divorced

W

B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Jane

8. (c) If alive, give age years

1872

8. AGE:

Years
73Months
2

Days

If less than one day
hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Salmon return

11. Industry or business

Brewing & Sedurick

12. Name

Vigil

13. Birthplace

Vigil

14. Maiden name

Agnes Peterson

15. Birthplace

Vigil

16. Informant

Janey P. Sedurick

Address

Prince Frederick

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Mar. 9, 1945

(month) (day) (year)

Cemetery or crematory

Christ Church

Location

Port Republic

18. Funeral director

A. O. Harkness & Son,

Address

Mutual, Inc.

19. (Date rec'd by registrar)

3-9

19. 45

S. W. King

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State

Md Va

County

Charles Co., Md, Va

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

31 7

1945 at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Acute myocarditis
acute dilatation

DURATION

377
10 min

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

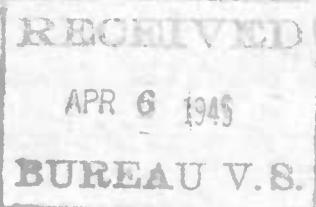
Injured at work?

23. SIGNATURE

M. D. or other

Address George W. Ward

Date signed 3/7/45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 8320

02704

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH: Calvert Co.
 County _____
 City or town Lower Marlboro md
(If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, Institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
 State Md County Calvert
 City or town Lower Marlboro md
(If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
(If rural, give LOCATION)

3. (a) FULL NAME Frances E. Smith
 4. Sex F 5. Color or race C 6.(a) Single, married, widowed, or divorced W
 6.(b) Name of husband or wife: _____
 7. Birth date of deceased (mo., day, yr.) T
 8. AGE: Years 63 Months _____ Days _____ If less than one day hrs. _____ min. _____
 9. Birthplace md
(Town, county, and state)
 10. Usual occupation Domestic
 11. Industry or business Isaac Coats
 MOTHER FATHER
 12. Name Isaac Coats
 13. Birthplace md
 14. Maiden name Amanda Johnson
 15. Birthplace md
 16. Informant Gladys Jones
 Address Lower Marlboro md
 17. St. John's (Burial) Date thereof 3-22-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Johns
 Location Calvert md
 18. Funeral director P.E. Dewell
 Address Pr. Frederick md
 19. 3-19-45 Date rec'd by registrar S. J. King
(Date rec'd by registrar) Registrar

3. (b) Social Security Number**MEDICAL CERTIFICATION**

20. DATE OF DEATH 3-19, 1945 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 2-1 1941 to 3-19 1945
 and that I last saw her alive on 3-19 1945

Immediate cause of death Cerebral accident

Due to Hypertension

Due to: _____

Other conditions: _____
(Include pregnancy within 8 months of death)

Major findings of operations: _____ Date of op. _____

Autopsy results: _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury Injured at work? _____

23. SIGNATURE M. D. or other _____

Address _____ Date signed _____

RECEIVED
APR 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

02705

CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age years

8. AGE:

Years Months Days If less than one day
36 3 14 hrs. min.

9. Birthplace

(Town, county and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof March 20, 1945
(month) (day) (year)

Cemetery or crematory

Location Friendship A. A. Co. Md.

18. Funeral director

Address Galesville Md.

19. March 19, 1945

(Date rec'd by registrar)

Wm. H. Herdsey

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

3/18 1945 at 8:30 A.M.

I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 4 1945 to Jan 18 1945 and that I last saw him alive on March 17 1945

Immediate cause of death

Coronary embolism
following surgery

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED
APR 5 1945
BUREAU V.E.

M PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
year of birth is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 14

02706

51

Reg. Dist. No.

FILM. G 54 MAY 11 1945

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.....

Calvert,

City or town.....

Wares, md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

life

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Florence Winston

4. Sex

F

5. Color or race

c.

6.(a) Single, married, widowed, or divorced

s

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of
deceased (mo. day, yr.)

July 10, 1932

8. AGE:

Years
13

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

md

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

FATHER

12. Name..... John Winston

13. Birthplace

md

MOTHER

14. Maiden name..... Sadie Wall

15. Birthplace

md

16. Informant.....

Address

Sadie Winston

Wares, md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....
(month) (day) (year)
3 - 14 - 45

Cemetery or crematory.....

Browns

Location.....

Calvert Co. md

18. Funeral director.....

P. E. Sewell

Address

Prince Frederick Rd

19. 3-14

19. 45

(Date rec'd by registrar)

I. N. King

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... md

County.....

Calvert

City or town.....

Wares

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

3 - 11 - 1945

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.....

to 19.....

and that I last saw h..... alive on

19.....

Immediate cause of death.....

Influenza Menengitis?

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

J. N. King

M. D. or other

Address..... Date signed..... 5/17/45

RECEIVED
APR 6 1945
BUREAU V.S.